No. 14-181

In The
Supreme Court of the United States

ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,
Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF FOR PETITIONER

DAVID C. FREDERICK
SCOTT H. ANGSTREICH
KELLOGG, HUBER, HANSEN, TODD, EVANS & FIGEL, P.L.L.C.
1615 M Street, N.W.
Suite 400
Washington, D.C. 20036
(202) 326-7900

PETER K. STRIS
BRENDAN S. MAHER
RADHA A. PATHAK
STRIS & MAHER LLP
725 S. Figueroa Street
Suite 1830
Los Angeles, CA 90017
(213) 995-6800

WILLIAM H. SORRELL
Attorney General
BRIDGET C. ASAY
Solicitor General
Counsel of Record
BENJAMIN D. BATTLES
Assistant Attorney General
OFFICE OF THE ATTORNEY GENERAL
109 State Street
Montpelier, VT 05609
(802) 828-3181
bridget.asay@vermont.gov

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QUESTION PRESENTED

Like many other States, Vermont has developed an all-payer database to support health care policy, regulation, and research. The law requires all public and private entities that pay for health care services provided to Vermont residents, including insurers, government programs, and third-party administrators, to transmit to the database certain claims data reflecting medical services and expenditures. The question presented is:

May Vermont apply its health care database law to the third-party administrator for a self-insured ERISA plan?

PARTIES TO THE PROCEEDING

Petitioner Alfred Gobeille, in his official capacity as Chair of the Green Mountain Care Board, has been substituted for Commissioner Susan Donegan, who was the appellee in the court of appeals. *See* Supreme Court R. 35.3. Chair Gobeille has been substituted because the Vermont Legislature shifted responsibility for the unified health care database to the Green Mountain Care Board, effective June 7, 2013. *See* 2013 Vt. Acts & Resolves, No. 79, § 40. The original defendant in the district court was Commissioner Stephen Kimbell. Commissioner Donegan was substituted as a party when she replaced Commissioner Kimbell in office.

The respondent, Liberty Mutual Insurance Company, was the appellant in the court of appeals and the plaintiff in the district court.

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INTRODUCTION

To carry out their traditional roles as the primary regulators of public health, States need comprehensive, high-quality information about health care services and the health care market. Vermont's health care data-collection program advances the State's paramount interest in the health, safety, and welfare of its citizens. Building on data-collection programs that date back decades, Vermont and many other States—often with federal support—have developed comprehensive databases to track the health care services that are provided to their residents and the cost of those services.

All insurers generate such data, which afford a full and accurate picture of health care spending and utilization. Vermont collects data from all payers of health services provided to Vermont residents, including health insurers and public benefit programs. These "claims data" are the data that insurers (and public programs like Medicaid) generate in the normal course of business, as they compensate health care providers for their services. Collected and analyzed, this information yields powerful insights about quality of care, cost, and accessibility.

The Second Circuit erroneously interpreted the Employee Retirement Income Security Act of 1974 (ERISA) in holding that Vermont's law is preempted as applied to self-insured plans. That holding is especially anomalous because Liberty Mutual's third-party administrator is a health insurer that already collects and reports claims data for itself and for other self-insured ERISA plans that it administers.

The Second Circuit's holding runs afoul of this Court's conclusion two decades ago that ERISA was not intended to displace the States' authority over

"general health care regulation." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995). Vermont's health care database statute has nothing to do with the purposes of ERISA and does not regulate the financing of the plan, the benefits offered, or the relationship between the plan and its members. It says nothing about how a plan must be structured and gives the State no authority to oversee its administration. Accordingly, ERISA does not preempt this Vermont statute.

OPINIONS BELOW

The opinion of the court of appeals (App. 1-47) is reported at 746 F.3d 497. The memorandum opinion and order of the district court (App. 48-80) is not reported, but is available at 2012 WL 5471225.

JURISDICTION

The judgment of the court of appeals was entered on February 4, 2014. A petition for rehearing was denied on May 16, 2014. App. 81-82. The certiorari petition was filed on August 13, 2014, and granted on June 29, 2015 (135 S. Ct. 2887). The jurisdiction of this Court rests on 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the U.S. Constitution provides:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing

in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. Const. art. VI, cl. 2.

The "other laws" provision of ERISA, 29 U.S.C. § 1144, is set forth at App. 83-90.

Vermont's health care database statute, Vt. Stat. Ann. tit. 18, § 9410, is set forth at App. 92-99. The Petition Appendix also includes the prior version of the statute, before a 2013 amendment that shifted responsibility for the database from the Vermont Department of Financial Regulation to the Green Mountain Care Board. App. 99-106.

The Regulation that governs the database, Regulation H-2008-01, is set forth at App. 107-41. The appendices to the Regulation (which provide data specifications and forms used for the database) are available online at http://gmcboard.vermont.gov/sites/gmcboard/files/REG_H-2008-01.pdf.

STATEMENT

I. Background

Building on longstanding efforts to collect health care data as a tool for improving public health—efforts that long predate ERISA—Vermont and many other States have created comprehensive health care databases.[1] Also known as an all-payer claims database, or APCD, Vermont's program collects information about the medical services provided to state residents, including the identity of the providers and the amount paid. Vermont uses these statewide utilization and spending data to improve the delivery of health care to Vermont residents and achieve better health care

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[1] At least 18 States have these databases in place or in development. *See* APCD Council, *Interactive State Map*, http://www.apcdcouncil.org/state/map.

outcomes; to develop strategies to control costs while improving quality of care; and to promote health care research. The State gathers this information by requiring health care payers, including insurers and third-party plan administrators, to pass along data they already have and generate in the ordinary course of business.

A. Vermont's history of health care data-collection and analysis

The States have long collected and analyzed information to promote the health of their residents. For well over a century, States have required doctors to report instances of infectious diseases. *See* 1900 Vt. Acts & Resolves No. 91, § 4; Ctrs. for Disease Control & Prevention, *Mandatory Reporting of Infectious Diseases by Clinicians*, 39 Morbidity and Mortality Weekly Report RR-9 (1990) (*Mandatory Reporting*).[2] Collecting data helps States contain the spread of disease and supports research aimed at better prevention and treatment programs. *See Mandatory Reporting*; *see also, e.g.*, Vt. Gen. Laws §§ 6099-6101 (1917) (directing board of health to maintain records of tuberculosis cases, "investigate the prevalence and extent" of the disease, and address education, prevention, and cure). Statistical research and data-collection efforts have supported state public health programs ranging from vaccination to combating drug abuse. *See, e.g.*, *Jacobsen v. Massachusetts*, 197 U.S. 11, 31 & n.+ (1905) (smallpox vaccination); *Whalen v. Roe*, 429 U.S. 589, 597-98 (1977) (drug abuse).

Other, broader efforts to compile public health data also predate ERISA and go back at least 50 years. In

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[2] *Available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/00001665.htm.

the early 1960s, researchers at the University of Vermont created one of the first statewide hospital data sets, consisting of patient discharge summaries submitted by Vermont hospitals. *See* Kerr L. White, *A Historical Look at Variations*, 24 Health Aff. 295 (2005); John E. Wennberg, *Tracking Medicine: A Researcher's Quest to Understand Health Care* 16 (2010). The program expanded to include census data, vital statistics, and Medicare claims records provided by Blue Cross/Blue Shield. *See generally* Wennberg, *Tracking Medicine* 3-6, 14-25. Beginning in 1972, the Cooperative Health Information Center of Vermont (CHICV) operated this database. *See* Coralea N. Lapenas, *CHICV's Role in Vermont Health Care* 1 (1979).[3]

Vermont's early data-collection efforts enabled groundbreaking research into the delivery of medical care in the State. A 1973 study revealed startling disparities in hospitalization and surgery rates across Vermont communities. *See* John Wennberg & Alan Gittlesohn, *Small Area Variations in Health Care Delivery*, 182 Sci. 1102 (1973); *see also* Wennberg, *Tracking Medicine* 18. As a result, physicians changed their practices to reduce unnecessary surgeries. *See* John E. Wennberg et al., *Changes in Tonsillectomy Rates Associated with Feedback and Review*, 59 Pediatrics 821 (1977). CHICV also "provide[d] reports to State and Federal Agencies, hospitals, the medical profession, and a variety of other data users." *CHICV's*

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[3] *Available at* http://www.ago.vermont.gov/assets/files/GCAI/CHICVs%20Role%20in%20Vermont%20Health%20Care.pdf. CHICV was a non-profit, "quasi-public" body whose board included, among others, a former governor and a federal judge. It received federal funds and later served the data-collection needs of several state agencies. *See CHICV's Role in Vermont Health Care* 2-10.

Role in Vermont Health Care 1; *see id.* at 21 (discussing uses of 1977 report on hospitalization data).

The federal government supported, funded, and at times mandated Vermont's health care data collection, both before and after ERISA was enacted. The compilation of the initial hospital discharge data set, its expansion, and the creation of CHICV were all undertaken with federal funds and pursuant to federal programs. *See* Wennberg, *Tracking Medicine* 14-17; *CHICV's Role in Vermont Health Care* 1-2, 6 & Figure 2. CHICV began in 1972 as a pilot "model health statistical center" under the Department of Health, Education and Welfare's cooperative health statistics program. *See CHICV's Role in Vermont Health Care* 6-7. That program was codified in 1974 by the same Congress that enacted ERISA. *See* Health Services Research, Health Statistics, and Medical Libraries Act of 1974, Pub. L. No. 93-353, 88 Stat. 362. This federal health statistics program sought to create a "coalition among the various levels of government—Federal, State, and local"—and provide for the "collection of any particular data element by the level of government that is best equipped to collect it." Edward B. Perrin, *The Cooperative Health Statistics System*, 89 Health Servs. Rep. 13 (1974).[4] CHICV evolved to serve the needs of Vermont's Professional Standards Review Organization and Health Systems Agency, both of which were subject to federal data-collection mandates.[5] *See CHICV's Role in Vermont Health Care*

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[4] *Available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1616237/.

[5] *See* Social Security Amendments of 1972, Pub. L. No. 92-603, § 249F, 86 Stat. 1329, 1429; National Health Planning and Resources Development Act of 1974 (NHPRDA), Pub. L. No. 93-641, §§ 1-3, 88 Stat. 2225, 2225-2257 (1975) (repealed in part

6-10 & Figure 2. Later, to comply with the Health Services Research, Health Statistics, and Health Care Technology Act of 1978, Pub. L. No. 95-623, § 5, 92 Stat. 3443, 3445, Vermont designated its Department of Health as the coordinating agency for health data activities. *See* Vt. Stat. Ann. tit. 3, app. exec. order 18-1 (No. 35-79 (1979)).

Although these early efforts achieved important successes, the available data were limited. Vermont's programs relied primarily on hospital discharge data. *See* Hamilton Davis, *Health Care, in Vermont State Government Since 1965*, at 384 (Michael Sherman ed., 1999).[6] But hospital data provide only a limited snapshot of health care services, even when combined with other information collected by CHICV. Vermont hospitals do not have records of treatment that Vermont residents receive elsewhere.[7] Care received outside the hospital setting, like doctors' visits and drugs prescribed, is not included. And, critically, those records do not allow researchers to track the care received by the same patient from different providers.[8] Contemporaneous federal and state reports acknowledged a

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1986); *see also Travelers*, 514 U.S. at 665 (noting that NHPRDA "provided for the organization and partial funding of regional 'health systems agencies' responsible for gathering data").

[6] Vermont continues to collect hospital discharge data pursuant to Vt. Stat. Ann. tit. 18, §§ 9410, 9456, and 9457

[7] Not surprisingly for a small State, Vermonters often receive out-of-state hospital care. *See* Michael Davis & Lori Perry, *2013 Vermont Health Care Expenditure Analysis: Legislative Version* 29 (2015) (about 20% of hospital discharges for Vermont residents in 2012 were from out-of-state hospitals), *available at* http://gmcboard.vermont.gov/sites/gmcboard/files/2013EA_includes_provider_FINAL_leg_short%20%282%29.pdf.

[8] As explained below, VHCURES complies with the federal Health Insurance Portability and Accountability Act of 1996

need for better information. *See, e.g., Final Report of the Governor's Commission on Medical Care* 3, 8 (1974) (noting that, although CHICV's data were "of invaluable assistance," there remained a dearth of "reliable current data necessary to plan and monitor the State's health care program"); Jennifer Robbins, *The Use of Population-Based Data for Rate Setting, in* 6 Integration of Information for Hospital Rate Setting (HEW Pub. No. 77-11722 (1976)) (explaining that, even with hospital data, regulators were "forced to examine information on the use of medical care resources in light that is seriously dimmed" because "no one has data on the whole system on a statewide basis"); Vt. Stat. Ann. tit. 3, app. exec. order 18-1 (No. 35-79 (1979)) (recognizing problem of "inadequate information" and need for health care data).

B. The Vermont all-payer database

As health care costs escalated, the demand for better information also grew. A 1992 Vermont report noted that it was impossible to accurately predict the consequences of proposed policies because the State lacked "the necessary data or analytical capability." *Final Report of the Vermont Blue Ribbon Commission on Health* 7-8 (1992). The report recommended new information-gathering tools to "develop the utilization and reimbursement data necessary for further planning design and management." *Id.* at 3. The Vermont Legislature accordingly directed a new state Health Care Authority to "establish and maintain a unified health care data base," which should reflect "all health

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(HIPAA), and patient identifying information is encrypted. *See infra* p. 11.

care utilization, costs and resources" in the State. 1992 Vt. Acts & Resolves No. 160, § 1.

That statute marked the beginning of Vermont's all-payer claims database. Initial attempts to rely on voluntary participation by major insurers did not succeed. Meanwhile, Maine and New Hampshire began building all-payer databases by mandating that insurers in those States report their spending data. *See* Me. Rev. Stat. tit. 22, § 8704; N.H. Rev. Stat. Ann. § 420-G:11-a; Patrick Miller et al., *All-Payer Claims Databases: An Overview for Policymakers* 4 (2010). In 2005, the Vermont Legislature took a similar approach and required health insurers to provide data on paid claims that was encrypted and de-identified to protect patient privacy. 2005 Vt. Acts & Resolves No. 71, § 312. Vermont's all-payer claims database—now known as the Vermont Health Care Uniform Reporting and Evaluation System or VHCURES—became operational in 2009.

VHCURES is designed to inform the State's health care policy, including its over-arching aim "to ensure that all residents have access to quality health services at costs that are affordable." Vt. Stat. Ann. tit. 18, § 9401(a) (App. 91); *id.* § 9410(a)(1) (App. 92). The statute sets forth goals for VHCURES, including:

> (A) Determining the capacity and distribution of existing resources.
>
> (B) Identifying health care needs and informing health care policy.
>
> (C) Evaluating the effectiveness of intervention programs on improving patient outcomes.
>
> (D) Comparing costs between various treatment settings and approaches.

(E) Providing information to consumers and purchasers of health care.

(F) Improving the quality and affordability of patient health care and health care coverage.

Id. § 9410(a)(1) (App. 92).

VHCURES contains information supplied by health care "payers"—that is, government agencies, insurers, and similar entities that *pay* for health care services provided to Vermont residents. *Id.* § 9410(c), (h), (j) (App. 94-99). The statute requires health insurers to provide data on paid claims to the Board. *Id.* § 9410(h) (App. 95-96). The federal government voluntarily supplies Medicare claims data to VHCURES and has authorized Vermont to include data on Medicaid claims. *See* U.S. CVSG Br. 18; Pet. 22 n.3; *see also* 42 U.S.C. § 1395kk(e) (authorizing use of Medicare claims data "to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use").

To encompass all entities that pay for care provided to Vermont residents, the database statute defines "health insurer" to include "any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to Vermont resident[s]." Vt. Stat. Ann. tit. 18, § 9410(j)(1)(B) (App. 98). The implementing rule notes that the term "may also include, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities." Regulation H-2008-01, § 3(X) (App. 112-13). Only insurers with 200 or more covered members living in Vermont (or receiving covered services in

Vermont) must provide information to the database. *Id.* § 3(Ab) (App. 113).

State Regulation H-2008-01 (App. 107-41) supplies further details of database administration.[9] It sets forth "requirements for the submission of health care claims data, member eligibility data, and other information relating to health care provided to Vermont residents or by Vermont health care providers." *Id.* § 1 (App. 107). Only information about paid claims must be provided, not claims that are denied. *Id.* § 5(A)(8) (App. 121). The rule also does not require information about the benefits the health insurer provides or any other aspect of plan administration or financing.

The statute and rule protect personal privacy. The statute requires compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), *see* Vt. Stat. Ann. tit. 18, § 9410(h)(2) (App. 96), and mandates that confidential information be "filed in a manner that does not disclose the identity of the protected person," *id.* § 9410(e) (App. 94-95). The regulation provides standards for encrypting information prior to submission, Reg. H-2008-01, § 5(A)(5) (App. 119-21), and prohibits submission of "direct personal identifiers," *id.* § 7(A)(5) (App. 128-29). And the law forbids public disclosure of such identifiers, including names, addresses, and Social Security numbers. Vt. Stat. Ann. tit. 18, § 9410(h)(3)(D) (App. 97-98). As the United States has explained, the Centers for Medicare and Medicaid Services (CMS) provide Medicare claims data "on the condition that

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[9] Regulation H-2008-01 was promulgated by the state agency that previously administered the database. The regulation remains in effect.

Vermont protect the privacy of the information." U.S. CVSG Br. 18 n.7.

C. Uses of VHCURES data

The State uses the VHCURES database to improve the delivery of medical care to its citizens and guide health care regulation and policy. Its usefulness is driven by two factors: that claims data are a readily available and accurate measure of health care utilization and spending; and that the database includes comprehensive *statewide* claims data. These databases are called "all-payer" because—building on earlier, more limited data sets—States sought to capture health care expenditures for as much of their population as possible. As of 2014, VHCURES included expenditures for more than 90% of the Vermont population. If VHCURES lost data from all self-insured plans, nearly 20% of that population would be excluded.[10] The database would be both less comprehensive and skewed, because private-sector workers covered by self-insured plans tend to be younger and healthier than the population as a whole. *See* New York et al. Cert. Amicus. Br. 7; *see also* U.S. CVSG Br. 22 (without data from self-insured plans, "databases will be significantly less comprehensive and thus not as useful").

1. The health care database is an invaluable public health tool, because it allows researchers to measure and compare not just cost, but utilization of

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[10] *See* Michael Davis & Lori Perry, *2013 Vermont Health Care Expenditure Analysis* 12 (2015), *available at* https://outside.vermont.gov/sov/webservices/Shared%20Documents/EA_includes_provider.pdf; Vermont Asthma Program, *The What, Who, Why, and How of All-Payer Claims Databases* 4 (2014), *available at* http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=14763&lid=3.

services and quality of care. The Vermont Department of Health uses VHCURES data in its public health programs. VHCURES is part of the Department's birth information network aimed at "preventing and controlling disease, injury, and disability." Vt. Stat. Ann. tit. 18, § 5087(b). The Department has also used the database to study the prevalence of asthma and the rate of emergency room visits and hospitalizations for asthma.[11]

Vermont's "Blueprint for Health" uses the database extensively. The Blueprint is "dedicated to achieving well-coordinated and seamless health services, with an emphasis on prevention and wellness, for all Vermonters." Dep't of Vt. Health Access, *Vermont Blueprint for Health Manual* 3 (2015); *see also* Vt. Stat. Ann. tit. 18, § 701(1). One of the Blueprint's key innovations is to provide enhanced payments—from Medicare, Medicaid, and the major commercial insurers—to participating providers that meet national quality standards. *See Blueprint for Health Manual* 6-13. The Blueprint relies on VHCURES to measure the program's success. *See, e.g.*, Vt. Blueprint for Health, *2011 Annual Report* 19 (2012). VHCURES data have shown, for example, not only that payments under the program have been offset by lower health care expenditures, but also that patients being treated by participating providers received more effective preventive care. *See* Vt. Blueprint for Health, *2014 Annual Report* 15-18 (2015); Vt. Blueprint for Health, *2013 Annual Report* 11 (2014). VHCURES also enables the Blueprint to provide regular profiles for service

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[11] Vt. Dep't of Health, *Burden of Asthma among the Medicaid Insured in Vermont* (2014), *available at* http://healthvermont.gov/research/asthma/documents/asthmamedicaidbrief_2014_10.pdf.

areas and individual practices "with comparative results for a set of standardized expenditure, utilization, and quality measures." Steven Thompson et al., *Evaluating Health Care Delivery Reform Initiatives in the Face of "Cost Disease,"* 18 Population Health Mgmt. 6, 7 (2015). These profiles give providers "data to assist in honing their quality improvement efforts." *2014 Annual Report* at 53, 83-84. The Blueprint plans to use these profiles to provide additional financial incentives for providers that coordinate care with their community partners and improve patient outcomes for their entire service area. *See id.* at 33-34.[12]

Outside researchers also use VHCURES data to study public health. The Dartmouth Atlas Project published a comprehensive report that documented "marked variation" in pediatric health care across Maine, New Hampshire, and Vermont—all States with APCDs. David Goodman et al., *The Dartmouth Atlas of Children's Health Care in Northern New England* 3 (2013). That report emphasizes the importance of all-payer claims databases "for understanding children's health care" because there are no alternative sources and, as a result, "pediatric health care often occurs within a black box where the type, quantity, and outcomes of care are unknown." *Id.* at 6-7. Researchers found significant differences by geography and type of insurer in the rate of drugs prescribed to children in New England. *See* Shelsey J. Weinstein et al., *Small Geographic Area Variations in Prescription Drug Use*, 134 Pediatrics 563, 566 (2014). And researchers also have used the data to investigate and document increases and variations in health care

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[12] The Blueprint was selected by the Centers for Medicare and Medicaid Services to participate in CMS's patient-centered medical home demonstration. *See 2011 Annual Report* at 31.

spending across the region. *See* Carrie H. Colla et al., *Tracking Spending Among Commercially Insured Beneficiaries Using a Distributed Data Model*, 20 Am. J. Managed Care 650 (2014).

2. The Green Mountain Care Board, which oversees key aspects of Vermont's health care system, routinely uses the database for its regulatory responsibilities. The Board approves health insurance rates, Vt. Stat. Ann. tit. 18, § 9375(b)(6), and relies in part on VHCURES data to evaluate whether rates are affordable and promote quality and access to care, *id.* tit. 8, § 4062(a)(3). The Board also reviews hospital budgets, *id.* tit. 18, § 9375(b)(7), and similarly uses the comprehensive VHCURES data to review utilization and expenditure assumptions in that process, *id.* § 9456(b). For example, all-payer data enable the Board to analyze the so-called "cost shift," that is, "the extent to which costs incurred . . . in connection with services provided to Medicaid beneficiaries are being charged to non-Medicaid health benefit plans and other non-Medicaid payers." *Id.* § 9456(b)(8).

3. Controlling the growth of health care costs is one of the most pressing issues facing state governments. VHCURES delivers data needed to understand how and why health care costs are rising. Vermont's goal is to provide its residents "access to quality health services at costs that are affordable." Vt. Stat. Ann. tit. 18, § 9401 (App. 91); *see also id.* § 9410 (App. 92) (directing Board to improve the health of Vermont residents and reduce the growth of health care costs while protecting access to health care and quality of care). Rising costs are not just a budget problem, but also a public health problem. Board-directed researchers have used VHCURES data to examine variations in health care pricing in the State.

See Michael Del Trecco et al., *Vermont Health Systems Payment Variation Report* 1 (2013) (finding "significant variation" between payers and hospitals and also "within the same hospital, same payer setting"). Researchers are also comparing growth in spending for commercial insurers and Medicaid, and looking at whether cost increases are driven by prices or utilization. *See, e.g.*, Truven Health Analytics & Brandeis Univ., *Vermont Health Spending Growth Drivers Commercial and Medicaid, 2008-2012: Presentation to the Green Mountain Care Board* (2015).[13]

Finally, the Vermont Legislature has directed the Board to pursue a data-driven approach to containing health care spending while improving the quality and efficacy of the care provided. The Board oversees payment reform pilot projects—that is, innovative approaches that seek to align payment with patient outcomes, provide incentives for controlling costs, and support coordinated, evidence-based treatment. *See generally* Vt. Stat. Ann. tit. 18 §§ 9375(b)(1), 9377. The Board must oversee and evaluate these initiatives, a task that relies on VHCURES's comprehensive picture of Vermont's health care landscape.

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[13] *See also* Univ. of Vt. Coll. of Med. et al., *Price Variation Analysis* (2014); Health Care Cost Inst., *2007-2011 Vermont Health Care Cost and Utilization Report* (2014); Vt. Dep't of Fin. Regulation, *Spatial Analysis Study: Development of Primary Care Service Areas* (2013); Onpoint Health Data, *Tri-State Variation in Health Services Utilization & Expenditures in Northern New England* (2010), all available at http://www.gmcboard.vermont.gov/VHCURES/Analytics_and_Reports.

D. ERISA's reporting requirements

Congress enacted ERISA "to protect . . . the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). The statute requires plans to be established and maintained pursuant to a written instrument and to have named fiduciaries with authority to control and manage the administration of the plan and its assets. *Id.* §§ 1102(a)(1), 1103(a).

ERISA's reporting, disclosure, and fiduciary duty requirements "insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Calif. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 327 (1997) (citation omitted). Plan administrators must annually file detailed financial and actuarial information with the Secretary of Labor, and must file additional reports with the Secretary when a plan winds up its affairs or when an employer fails to make a payment required under ERISA's minimum funding standard. *See* 29 U.S.C. §§ 1021-1025. Health insurance and other welfare plans, however, generally are exempted from most of ERISA's reporting requirements. *See* 29 C.F.R. §§ 2520.103-1, 2520.104-20, 2520.104-44; *see also* 29 U.S.C. § 1024(a)(3); U.S. CVSG Br. 2.

With certain exceptions, ERISA preempts "any and all State laws insofar as they . . . relate to any employee benefit plan" covered by the statute. 29 U.S.C.

§ 1144(a). This Court, recognizing the "frustrating difficulty" of construing the term "relate to," *see Travelers*, 514 U.S. at 656, has rejected a "strictly literal reading" of ERISA's preemption clause. *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 (1997). The Court instead looks to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Travelers*, 514 U.S. at 656.

II. Procedural History

A. District court proceedings

Respondent Liberty Mutual filed this suit to block Vermont from obtaining claims data for its employee health plan. Liberty Mutual, an insurance company based in Massachusetts, provides health care for about 80,000 employees, retirees, and their families through a self-funded plan governed by ERISA. Liberty Mutual is the "named fiduciary" and "plan administrator" for ERISA purposes. App. 7-8, 50.

Liberty Mutual contracts with a third-party administrator, Blue Cross Blue Shield of Massachusetts, to administer the plan. App. 8, 50-51. Blue Cross "processes medical claims . . . , receives participants' confidential medical records and generates claims data." App. 50-51. Blue Cross is a mandated reporter for Vermont's database, because Blue Cross provides or administers benefits for several thousand Vermonters, including the 137 members of Liberty Mutual's plan who live in Vermont. App. 7-8, 50; JA205. Because of its small number of Vermont participants, Liberty Mutual itself is not required to provide information for Vermont's database. App. 8, 58.

In 2010, Blue Cross provided claims data for 7,605 individuals to VHCURES, including 3,667 members of self-insured plans. JA205; *see* App. 72-73 n.5. In 2011,

after learning that Liberty Mutual had instructed Blue Cross not to report data to VHCURES for Liberty Mutual's Vermont participants, the Department of Financial Regulation (previously responsible for the database) subpoenaed the information from Blue Cross. JA30-33. Liberty Mutual refused to allow Blue Cross to report information for its Vermont beneficiaries. App. 9, 56.

Liberty Mutual then filed this lawsuit, claiming that ERISA preempts any requirement that its third-party administrator (Blue Cross) provide information to Vermont's health care database. JA12-29. The State moved to dismiss; Liberty Mutual moved for summary judgment. App. 9, 49. With the agreement of the parties, the district court treated the motions as cross-motions for summary judgment. *Id.* In a written decision, the court rejected Liberty Mutual's preemption claim and granted judgment to the State. App. 48-80.

In ruling for the State on Liberty Mutual's claim of preemption, the district court first held that the database statute does not have a "reference" to ERISA plans. App. 69. As the court explained, the law requires numerous entities, including insurers and providers, to supply information to the database. *Id.* Therefore, "Vermont's statute and regulation do not act immediately and exclusively upon ERISA plans, nor is the existence of ERISA plans essential to their operation." *Id.*

Second, the district court concluded that the database statute does not have an impermissible "connection with" an ERISA plan. App. 69-78. After surveying this Court's decisions and relevant circuit precedent, the court emphasized that Vermont's law: (i) did not "attempt to control, supersede or interfere with the operation of an ERISA plan"; (ii) "has no

effect whatsoever on the core relationships that ERISA was designed to protect—those between participants, beneficiaries, administrators and employers"; and (iii) has "no effect whatsoever on the core ERISA functions—such as processing claims or disbursing benefits." App. 79.

The district court recognized that even a generally applicable law might be preempted if it "creates an economic effect so acute as to dictate certain administrative choices." App. 72. Here, however, Liberty Mutual had no reporting obligations at all, and there was "no evidence" that its third-party administrator, Blue Cross, was "laboring under any sort of burden" in complying with the law. App. 72 n.5. Indeed, Blue Cross provided information to VHCURES for other ERISA plans. App. 73 n.5. Liberty Mutual did "not submit[] any information about any actual burden suffered by itself or [Blue Cross] in producing this information." *Id.*

B. Second Circuit decision

On appeal, a divided Second Circuit reversed. App. 1-47. While agreeing with the district court that Vermont's statute and regulation "lack 'reference to' an ERISA plan," App. 23 n.9, the majority held that Vermont's law has an impermissible "connection with" ERISA plans, App. 23. The court viewed "reporting" as a core ERISA concern that is undermined by any state requirement for "plan record-keeping, and filing with a third party," and emphasized that Vermont's database "is called the 'Vermont Healthcare Claims Uniform *Reporting* and Evaluation System.'" App. 23-24. The court, moreover, concluded that "health

data collection" is not among "the states' historic police powers." App. 18 n.8.

The Second Circuit concluded further that only a "slight reporting burden" on self-insured plans would be permissible under ERISA. App. 24. The majority saw Vermont's "scheme" as "obviously intolerable," describing the claims data reporting requirements as "burdensome, time-consuming, and risky." App. 25. The court reasoned that any "burdens and risks must be multiplied" because of unspecified reporting requirements in other States. App. 29. The court described Vermont's detailed confidentiality provisions as "complex but loose" and suggested that the regulation was problematic because it could be changed in the future. App. 27-28.

Based on this reasoning, the majority held Vermont's law preempted. App. 23-29.

Judge Straub dissented. App. 30-47. He maintained that Vermont's health care database is "wholly distinct" from ERISA's reporting requirements and seeks "after-the-fact information which plan administrators . . . already have in their possession." App. 38, 39. Judge Straub agreed with the Department of Labor's position that "the focus and purpose of Vermont's data collection is different from the reporting requirements in ERISA." App. 38. As he found, the "Vermont statute regulates health care within that state, while imposing a purely clerical burden on ERISA plans." App. 46. The law "does not hinder the national administration of employment benefit plans" or require any "distinction in benefits between Vermont and any other state." App. 44. For Judge Straub, that "end[ed] the inquiry." *Id.*

Judge Straub also criticized the majority for failing to apply the presumption against preemption. App.

33-34. He noted further that the majority's description of Vermont's reporting requirement as "time-consuming and risky" was "pure speculation" because there was "no evidence to support such a finding." App. 46.

SUMMARY OF ARGUMENT

I. This Court's precedents provide no basis for finding preemption in this case. ERISA governs the financial solvency of employee benefit plans, the conduct of plan fiduciaries, and the content and performance of the promise to pay benefits to employees. As this Court has consistently recognized, however, ERISA leaves undisturbed "myriad" state laws and regulations that have some effect on ERISA plans, but do not regulate their terms or otherwise undermine ERISA's core objectives. *See, e.g.*, *De Buono*, 520 U.S. at 815; *Dillingham*, 519 U.S. at 334; *Travelers*, 514 U.S. at 661, 668. In particular, Congress did not intend ERISA to supplant the States' traditional responsibility for "general health care regulation." *Travelers*, 514 U.S. at 661.

Vermont's statute concerns health care, not benefit plans. Vermont's database statute serves traditional public health and regulatory purposes. Not only have States long relied on data collection for public health purposes, but also the federal government has financially supported and relied on these state programs. There is no reason to conclude that Congress intended ERISA to preempt a state statute that gathers information on payments for health care for public health purposes, and does not address—indeed, is indifferent to—the manner in which ERISA plans are administered.

The relevant question is not, as the Second Circuit suggested, whether ERISA is concerned with plan

reporting and disclosures to participants. It is. *See, e.g.*, *Travelers*, 514 U.S. at 661. The relevant inquiry is whether Vermont's effort to collect comprehensive statewide data about health care spending and services interferes with any of ERISA's core objectives. It does not. The state law merely requires Blue Cross—Liberty Mutual's third-party administrator—to transmit certain claims data it generates as a matter of course. There is no meaningful difference between Vermont's statute and other generally applicable state laws that this Court has upheld against ERISA challenges.

II. The Second Circuit's conclusion that providing claims data is burdensome and threatens patient confidentiality has no support in the record and should be disregarded. As both the district court and the dissenting judge below recognized, Liberty Mutual supplied no evidence that its third-party administrator was "laboring under any sort of burden" in supplying the data. App. 72 n.5; App. 39 (Straub, J., dissenting). The third-party administrator, Blue Cross Blue Shield of Massachusetts, has the claims data and provides them to Vermont for itself and other ERISA plans for which it serves as the third-party administrator. And any suggestion that the database program threatens patient confidentiality is unfounded. Personal identifying information is encrypted, and the program complies with HIPAA's privacy requirements. Indeed, the federal government provides Medicare claims data "on the condition that Vermont protect the privacy of the information." U.S. CVSG Br. 18 n.7.

ARGUMENT

I. Applying established principles for ERISA preemption, Vermont's health care database law is not preempted.

This Court repeatedly has rejected a "strictly literal reading" of ERISA's preemption clause, which preempts "any and all State laws insofar as they . . . relate to any employee benefit plan" covered by the statute. *De Buono*, 520 U.S. at 812-13; 29 U.S.C. § 1144; *see also Travelers*, 514 U.S. at 655-56. Initially construing that preemption provision, the Court observed that a "law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97 (1983). In *Travelers*, however, the Court cautioned against "uncritical literalism" in construing either "relates to" in the statute or the "connection with" gloss in *Shaw*. *Travelers*, 514 U.S. at 656. Neither "infinite relations" nor "infinite connections" can be the "measure of pre-emption." *Id.*[14]

In *Travelers*, the Court re-focused the preemption analysis on Congress's intent in passing ERISA. There and in subsequent decisions, the Court has looked "to the objectives of the ERISA statute as a guide to the scope of the state law that Congress

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[14] The "reference to" prong of the two-part *Shaw* test is not at issue in this case. The Second Circuit correctly held that the "Vermont statute and regulation lack 'reference to' an ERISA plan because they apply to all health care payers and do not act 'exclusively upon ERISA plans.'" App. 23 (quoting *Dillingham*, 519 U.S. at 325). Liberty Mutual did not argue otherwise below or contest this point in its opposition to the petition for certiorari. *See* Opp. 14 (defending Second Circuit's application of "connection with" test); Liberty Mutual C.A. Br. 20 (relying on "connection with" prong).

understood would survive." *Id.*; *Dillingham*, 519 U.S. at 325; *De Buono*, 520 U.S. at 813-14. This precedent establishes that ERISA does not override "general health care regulation" or otherwise displace traditional state regulation in areas where "ERISA has nothing to say." *Travelers*, 514 U.S. at 661; *Dillingham*, 519 U.S. at 330. The balance Congress struck in ERISA leaves ample room for generally applicable state laws that govern health care, including Vermont's health care database statute.

A. ERISA does not preempt generally applicable state health care regulations that neither mandate particular employee benefits nor interfere with plan administration.

As this Court has explained, ERISA does not supplant the States' traditional role in regulating health care. *See De Buono*, 520 U.S. at 814-16; *Travelers*, 514 U.S. at 654-55. Those cases upheld generally applicable state health care laws, despite financial and regulatory burdens on ERISA plans. *Travelers* and *De Buono* establish two fundamental principles that control the outcome of this case: first, the preemption inquiry is measured by Congress's objectives in enacting ERISA; and, second, Congress did not intend ERISA to displace generally applicable state health care regulations.

1. The scope of ERISA's preemption language is guided by the "objectives of the ERISA statute." *Travelers*, 514 U.S. at 656. *Travelers* and the Court's subsequent rulings in *Dillingham* and *De Buono* require courts to analyze not the potential breadth of the phrase "relate to," but rather the "type of state law that Congress intended ERISA to supersede." *De Buono*, 520 U.S. at 814.

Three core objectives of ERISA bear on the scope of preemption: (i) ensuring that plans act as fiduciaries and provide the benefits promised to plan beneficiaries; (ii) providing an exclusive mechanism to enforce ERISA's protections; and (iii) establishing a uniform body of law to govern the provision and funding of benefits.

First, ERISA was intended to protect beneficiaries. Congress was gravely concerned with "mismanagement of funds" and the "failure to pay employees benefits from accumulated funds." *Dillingham*, 519 U.S. at 326-27 (quoting *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989)). Congress wanted employers to keep their promises to employees and wanted funds to be preserved for their intended uses, not squandered through malfeasance or negligence. *See* 29 U.S.C. § 1001(b) (declaring ERISA's policy to protect plan participants and their beneficiaries). "To that end, [Congress] established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Dillingham*, 519 U.S. at 327 (quoting *Morash*, 490 U.S. at 115).

Second, ERISA provides an "integrated enforcement mechanism" against plan administrators that Congress intended to be "exclusive." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208-09 (2004) (construing 29 U.S.C. § 1132). State laws that "provid[e] alternative enforcement mechanisms" against plan administrators are generally preempted. *Travelers*, 514 U.S. at 658.

Third, Congress sought to establish a "uniform body of *benefits* law" that avoids "conflicting directives" and allows for "nationally uniform administration of

employee benefit plans." *Travelers*, 514 U.S. at 657 (emphasis added, quotations omitted). In this context, "uniform administration" refers to the provision and funding of benefits. States thus may not require "employers to pay employees specific benefits," *id.* (quoting *Shaw*, 463 U.S. at 97); prohibit plans from "requiring reimbursement in the event of recovery from a third party," *id.* (quoting *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990)); prohibit set-offs for worker's compensation benefits, *id.* at 658 (citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981)); or change the rules for beneficiary designations, *see Egelhoff v. Egelhoff*, 532 U.S. 141 (2001) (state law preempted because it automatically revoked, upon divorce, designation of a spouse as the beneficiary of a nonprobate asset); *Boggs v. Boggs*, 520 U.S. 833 (1997) (state community property law preempted insofar as it would assign ownership interest in ERISA plan benefits to person other than designated beneficiary).

But ERISA does not preempt every state law that has some effect on an ERISA plan or regulates some aspect of plan activities. There are, as the Court has observed, "myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." *Travelers*, 514 U.S. at 668. That these state laws impose costs and administrative burdens on a plan is unremarkable—ERISA did not transform plans into islands isolated from all regulation—and not a basis for finding preemption. *See, e.g., De Buono*, 520 U.S. at 815 (upholding state hospital tax that increased cost for plans and "impose[d] some burdens" on plan administration) (quotations omitted); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 831

(1988) (holding that ERISA did not preempt application of generally applicable state garnishment statute to benefits held by ERISA plan, despite plan's contention that compliance would impose "substantial administrative burdens and costs"); *see also Travelers*, 514 U.S. at 662 (noting that, in *Mackey*, the Court "took no issue with the argument . . . that garnishment would impose administrative costs and burdens upon benefit plans").[15] Although Congress sought to foster uniform benefit plans, its preemption of state laws that "relate to" ERISA plans did not mandate "a degree of preemption that no sensible person could have intended." *See Dillingham*, 519 U.S. at 335-36 (Scalia, J., concurring).

By focusing on Congress's objectives in enacting ERISA, the Court properly limited the reach of the statute's preemption clause. ERISA preempts state laws that direct the amount, type, or nature of benefits paid to beneficiaries; regulate the structure of the plan; or otherwise interfere with the relationship between a plan and its members. *See, e.g., De Buono*, 520 U.S. at 814-15 (distinguishing permissible tax on hospitals from state laws that address "calculating of pension benefits" or require payment of specific benefits); *Travelers*, 514 U.S. at 658 (describing past decisions where "ERISA pre-empted state laws that mandated employee benefit structures or their administration"); *see also Egelhoff*, 532 U.S. at 150 (ERISA

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[15] The Court has left open the possibility that a state law might impose economic burdens "so acute as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers' and such a state law 'might indeed be pre-empted under [29 U.S.C. § 1144].'" *De Buono*, 520 U.S. at 816 n.16 (quoting *Travelers*, 514 U.S. at 668). Neither Liberty Mutual nor the lower court has suggested that Vermont's database requirements even approach this standard. *See* Opp. 19-20 & n.9.

preemption was intended to avoid "different state regulations affecting an ERISA plan's 'system for processing claims and paying benefits.'") (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987)). It does not preempt a law like Vermont's database law, which is utterly indifferent to—and indeed incapable of assessing—whether ERISA plans remain solvent, behave prudently, or keep their insurance promise.

2. Congress also did not intend ERISA to displace ordinary state health care regulations. Under *Travelers* and *De Buono*, those seeking to preempt generally applicable state laws that govern the health care industry from applying to ERISA plans face a "considerable burden." *De Buono*, 520 U.S. at 814. "[N]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661.

Consistent with this understanding of Congress's intent, the Court in *Travelers* upheld a New York regulation of hospital rates that imposed additional costs on commercial health insurers acting as fiduciaries for ERISA plans. The law required hospitals to charge commercial insurers up to 24% more than Medicaid and Blue Cross/Blue Shield plans. *Id.* at 650. The Second Circuit—which held the law preempted—observed that the surcharges were "meant to increase the costs of certain insurance" and "impose[d] a significant economic burden" on the plans. *Id.* at 654. This Court reversed, explaining that a broad range of state health care regulations "affect[] costs and charges" for ERISA plans purchasing health insurance coverage and are not preempted. *Id.* at 661.

The Court reiterated this point in *De Buono*, where the Second Circuit had struck down a state tax on hospital revenues as applied to a hospital operated by an ERISA plan. The lower court had "rested its conclusion in no small part on the fact that" the tax targeted the health care industry. *De Buono*, 520 U.S. at 814 n.10. This Court reversed, noting that, "[r]ather than warranting pre-emption," that point instead called for applying the presumption against preemption. *Id.* "'[M]yriad state laws' of general applicability . . . impose some burdens on the administration of ERISA plans." *Id.* at 815. The tax did not target ERISA plans, because "[m]ost hospitals are not owned or operated by ERISA funds." *Id.* at 816. That the tax "increase[d] the cost of providing benefits to covered employees," and thus had "some effect on the administration of ERISA plans," was not enough to find preemption. *Id.*

ERISA regulates employee benefit plans. It does not regulate health care. Those central teachings, distilled from *Travelers* and later cases, confine ERISA preemption to a reasonable scope and avoid the "unsettling result," *Travelers*, 514 U.S. at 665, of invalidating large swaths of state law regarding matters "where ERISA has nothing to say," *Dillingham*, 519 U.S. at 330.[16]

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[16] Several justices have suggested that ERISA's preemption clause may be better understood as "identify[ing] the field in which ordinary *field pre-emption* applies—namely, the field of laws regulating" employee benefit plans covered by ERISA. *Dillingham*, 519 U.S. at 336 (Scalia, J., concurring, joined by Ginsburg, J.); *see also Egelhoff*, 532 U.S. at 153 (Scalia, J., concurring, joined by Ginsburg, J.) (arguing that "relate to" should be interpreted as "a reference to "ordinary pre-emption jurisprudence"); *id.* at 153 (Breyer, J., dissenting, joined by Stevens, J.) (agreeing with Justice Scalia that Court "should apply normal

B. Vermont's law does not intrude on a core ERISA function and is not the type of law that Congress intended ERISA to preempt.

Applying these settled principles, Vermont's law must be upheld. First, the health care database statute is the type of "general health care regulation" that Congress left undisturbed when it adopted ERISA. Second, the database statute merely requires that third-party administrators provide after-the-fact claims data for self-insured plans in the same way that they provide data for other plans and insureds. Nothing about this requirement intrudes on a core ERISA function or in any way changes the terms of the benefit plan. Third, other federal statutes coupled with consistent federal support for state data-collection programs confirm that Liberty Mutual's assertion of federal preemption has no reasonable basis.

1. Vermont's law is an exercise of traditional and longstanding state authority to regulate health care.

The decision of Vermont and other States to create all-payer claims databases implicates longstanding state oversight of health care. The Second Circuit erroneously concluded that these "health data collection laws" do not fall within the "states' historic police powers." App. 18 n.8. In fact, States need comprehensive, high-quality data to carry out their traditional role of safeguarding public health as the primary regulators of health care providers and the health care market. And although the particular type of data collection at issue in this case is relatively new, States'

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conflict pre-emption and field pre-emption principles"). If viewed through a field preemption lens, the result is the same: *Travelers* and *De Buono* establish that health care regulation is outside of the preempted field governed by ERISA.

interest in collecting health information is not. From controlling contagious diseases over a century ago to federally supported health planning efforts in the 1970s, States routinely have collected health information to protect the public and better manage their health care systems. *See supra* pp. 4-8. This is no different.

The uses of data from VHCURES and other States' databases prove this point. Health care databases serve the States' traditional interests in protecting public health, regulating the health care industry, and developing health care policy. *See supra* pp. 12-16. In concluding otherwise, the Second Circuit drew an artificial distinction between collecting information and regulating the safe provision of health care.

First, health care databases are vital public health programs. States cannot reasonably be expected to oversee health care providers, support disease prevention, and improve the quality of health care without systematically collecting and analyzing health care data. Research conducted across the country confirms this point. Colorado is studying claims data to evaluate post-surgery prescriptions for opioids, in an effort to increase patient safety by reducing unnecessary use of addictive painkillers.[17] The Dartmouth Institute relies on data from three state databases to track children's health care in northern New England. *See supra* p. 14. New Hampshire has looked at problems with local access to medical services, while Utah uses its data to study preventive care. A regional pilot project in New York found a high rate of unnecessary hysterectomies. *See* New York et al. Cert. Amicus. Br.

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[17] *See* APCD Showcase, *Identify Opportunities to Reduce Use of Potentially Harmful Medications During and Post Surgery* (2015), http://www.apcdshowcase.org/case-studies/.

5-6. In Vermont, the health care database supports the Blueprint for Health, the State's federally recognized program aimed at improving the treatment of chronic diseases such as diabetes, asthma, and heart disease. *See supra* pp. 13-14.

Second, Vermont, like other States, needs accurate information about the health care market to carry out traditional state regulatory functions. As in many States, health insurers in Vermont must submit their proposed rates for review and approval. *See* Vt. Stat. Ann. tit. 8, § 4062(a)(1), (3).[18] In reviewing rates, the Green Mountain Care Board relies in part on information about health care spending and utilization drawn from VHCURES. And the Board's review of hospital budgets, a longstanding part of the State's effort to control health care costs, also draws on VHCURES. *See supra* p. 15. Without data from self-insured plans—which pay for health care services for a substantial number of Vermont residents—VHCURES would be far less complete and accurate, and thus materially less useful, for these purposes.

Third, comprehensive all-payer databases are a tool for addressing one of the most serious budget and public policy issues facing States: the ever-increasing cost of health care. The annual growth in health care spending has outstripped inflation for decades.[19]

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[18] The scope of rate review varies by State, but the majority of States have some process for reviewing health insurance rates. *See, e.g.*, Kaiser Family Found., *Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable* 19-23 (2010), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8122.pdf.

[19] *See, e.g.*, CMS, Historical National Health Expenditure Data, Table 2, https://www.cms.gov/Research-Statistics-Data-

Controlling the rate of growth is crucial to the long-term fiscal outlook for state governments. *See, e.g.*, U.S. Gov't Accountability Office, *State and Local Governments' Fiscal Outlook* 5 (2014 Update) (noting that "growth in health-related costs" is "a primary driver of long term-fiscal challenges for the state and local government sector").[20] Put more simply, the ability of a State to balance its budgets for the next several decades will depend in substantial part on whether all levels of government achieve success in bending that cost curve. *See id.* at 2 (given rising health care costs, state and local governments "need to make substantial policy changes to avoid fiscal imbalances that would likely grow in the future").

Vermont has invested in its all-payer database because it is the most effective means of assembling the comprehensive data the State needs to develop and evaluate policies aimed at controlling health care costs. *See, e.g.*, Vt. Stat. Ann. tit. 18, § 9410(a)(1)(B), (D), (F) (purposes include "informing health care policy," comparing costs, and "improving the quality and affordability" of health care); *see supra* pp. 15-16 & n.13 (noting state reports and studies drawing on VHCURES data). One of the primary statutory directives to the Green Mountain Care Board, which maintains the database, is to "reduc[e] the per capita rate of growth in expenditures" while "maintaining quality of care." Vt. Stat. Ann. tit. 18, § 9372. As just one example of the ways in which it pursues that dual directive, the Board supervises payment-reform pilot projects that move away from paying providers for specific services and, instead, develop payment

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and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

[20] *Available at* http://www.gao.gov/assets/670/667623.pdf.

systems that reward better care and better patient outcomes. *See generally id.* § 9377. The goal is to find better ways to pay for health care—not by trying to change the entire system, all at once, but by designing and implementing smaller projects and studying their success. VHCURES, with its statewide data on utilization and spending, is essential to both developing reform proposals and evaluating their successes or failures.

Other States with all-payer claims database statutes agree that these laws "provide the States with data they need to improve the quality of care while controlling costs." New York et al. Cert. Amicus. Br. 4. The States will not all adopt identical policies to meet these challenges. But the widespread commitment of public resources to establish these databases —in States as diverse as Vermont, New York, West Virginia, Utah, and Colorado—represents a common effort to craft policy based on the best information available. No one can fix a system that no one understands.

The Second Circuit's suggestion that these important tools for collecting health care data are somehow outside the States' historic police powers is thus mistaken. The databases that Vermont and other States have created serve broad public health and health policy purposes. This is precisely the kind of "general health care regulation" that "historically has been a matter of local concern" and that Congress did not intend ERISA to override. *Travelers*, 514 U.S. at 661.

2. Vermont's law does not intrude on a core ERISA function and has nothing to do with ERISA's plan reporting requirements.

Although Vermont's law serves critical information-gathering functions, it is limited in scope. The health care database statute does not regulate the terms of an employee benefit plan, interfere with the relationship between a plan and its members, or supervise plan funding or fiduciary obligations. Moreover, the information Vermont seeks would not even be useful for any of those purposes. The State is not asking for any information about the terms of the plan or its funding. App. 118-21. Nor is it asking for information about claims that are denied. App. 121. The names of plan members are encrypted and the use of VHCURES data to evaluate particular employers is prohibited. App. 110, 129, 135. In short, the information Vermont seeks about statewide health care utilization and spending has no connection with those areas that ERISA carves out as matters of federal concern. Given this sharp disconnection between the objectives of ERISA and the purpose and effect of Vermont's database, there is no reasonable basis for holding this state health care regulation preempted.

a. The nature and purpose of ERISA's reporting requirements show that Vermont's law is not preempted. Consistent with the Court's reasoning in *Travelers*, the proper focus is on what Congress intended ERISA to accomplish. *See* 514 U.S. at 656 (looking to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive"). And what animated ERISA's reporting and disclosure requirements was the need to protect plan beneficiaries. ERISA's policy

statement declares that, "owing *to the lack of employee information* and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries . . . *that disclosure be made* and safeguards be provided with respect to the establishment, operation, and administration of such plans." 29 U.S.C. § 1001(a) (emphases added). Congress expressly tied the disclosure and reporting standards to the federal interest in protecting plan participants:

> It is . . . the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

Id. § 1001(b).

This Court's precedents acknowledge the same point. "The principal object of [ERISA] is to protect plan participants and beneficiaries." *Boggs*, 520 U.S. at 845. As the Court explained in *Massachusetts v. Morash*, "Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." 490 U.S. at 115. It was, the Court has repeatedly noted, "*to that end*" that Congress "established extensive reporting, disclosure, and fiduciary duty requirements." *Id.* (emphasis added); *see also Dillingham*, 519 U.S. at 326-27 (same). The federal government, which enforces the reporting and disclosure requirements, agrees that ERISA plan

reporting requirements "serve the basic purposes of ERISA," namely, preventing mismanagement of funds and failure to pay benefits. U.S. CVSG Br. 13; *see id.* at 2-3 (describing ERISA's reporting requirements).

Vermont's collection of after-the-fact health care claims information from all payers, including third-party administrators of self-insured ERISA plans, in no way intrudes on these areas of federal concern and regulation. The program is not directed at ERISA plans as *plans*. VHCURES has "an entirely different focus," *id.* at 13: collecting statewide paid claims data as a tool for improving public health and guiding health care policy. The database requirements apply across-the-board to public and private health care payers. Indeed, Liberty Mutual's third-party administrator, a major health insurer, provides the same claims data to the database whether the person receiving benefits is part of an ERISA plan or not.[21]

The information provided to VHCURES contributes to a comprehensive picture of health care spending and utilization. But it does not provide any path to assess the administration or audit the financing of an employee benefit plan. Vermont could not evaluate whether a plan has provided the benefits promised to employees, because it does not collect information about the plan terms and does not ask for information about claims denied by the plan.[22] Likewise, Vermont

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[21] In 2010, the year before this suit was filed, Blue Cross Blue Shield of Massachusetts supplied claims data to VHCURES for more than 7,000 covered individuals, about half of whom were covered by self-insured plans for which Blue Cross served as third-party administrator. JA205.

[22] Review of the "claims procedure" set forth in plan documents further illustrates that the database statute has no relationship to the plan's administration of claims. The plan directs how a

could not evaluate whether a plan is adequately financed, because it does not collect information about finances. When data are used for research purposes, employer and purchaser groups may not even be disclosed. App. 135. The database statute serves broad public policy goals. It does not protect beneficiaries or supervise the relationship between the plan and its members.

In holding Vermont's law preempted, the Second Circuit failed to consider the nature and purpose of ERISA's reporting requirements—indeed, the court criticized the dissent for engaging in that analysis and ignored the federal government's arguments on this point. *See* App. 24 n.11, 29 n.13; U.S. C.A. Br. 12-13 (explaining that Vermont's law does not affect the relationship between the plan and its members and does not serve the same purpose as ERISA's reporting requirements). But that is precisely the inquiry called for by this Court's precedents. *See Travelers*, 514 U.S. at 656; *Dillingham*, 519 U.S. at 325; *De Buono*, 520 U.S. at 813-14. Vermont's health care database does not affect employee benefit plans in any way that undermines the objectives of ERISA.

b. Moreover, the Second Circuit's contrary conclusion is based on a mistaken premise: that, because ERISA requires certain plan reporting and disclosures, reporting information of any kind must be deemed a "core ERISA function." App. 23-24. ERISA's reporting and disclosure requirements, however, are designed to help achieve the statute's key objectives:

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claim must be filed, the time for decision, and the appeal process for denied claims. JA44-46. The claims data submitted to VHCURES would not even reveal that process, much less affect it. The paid claims data disclose the final amount paid to providers and the services for which payment is made.

protecting beneficiaries, ensuring financial solvency, and facilitating uniform plan administration. ERISA plans provide an annual report to the Secretary of Labor, *see* 29 U.S.C. § 1023, which is "principally concerned with the financial soundness of the plan." U.S. C.A. Br. 12.[23] The plan's disclosure to plan participants, *see* 29 U.S.C. §§ 1021-1022, "is essentially a plain-English summary of key plan terms." U.S. C.A. Br. 12. By setting a federal standard for these disclosures, ERISA allows plans to send the same notices to all participants, wherever they live, and ensures that members receive a consistent, fair explanation of the plan. ERISA sets those requirements, and States cannot alter or duplicate them. *See* U.S. CVSG Br. 13 ("Any state-law reporting requirements serving the same functions would raise a substantial preemption question.").

But the fact that Congress adopted plan reporting requirements for the purpose of protecting beneficiaries, *see Dillingham*, 519 U.S. at 326-27, does not mean —as the Second Circuit incorrectly concluded—that requiring a plan to provide information for any purpose, in any context, intrudes on a core ERISA function. *See* App. 24. Plans necessarily engage in a wide range of activities that might trigger state-law requirements to keep records or provide information to a state or local government. Plans may purchase real estate, and need to comply with recording, reporting, and property tax requirements.[24] State tax laws

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[23] As a general matter, welfare plans are exempt from most reporting requirements. *See* U.S. CVSG Br. 2; 29 C.F.R. §§ 2520.103-1, 2520.104-20, 2520.104-44.

[24] *See, e.g.*, Vt. Stat. Ann. tit. 32, § 4004 (requiring every "taxable person" to prepare and return inventory forms for property tax purposes); *id.* §§ 9602, 9606 (imposing tax on transfer of title

or prevailing wage laws may require information from plans. *Cf. De Buono*, 520 U.S. at 809-10, 815-16; *Dillingham*, 519 U.S. at 330, 334. ERISA contemplates that plans may offer not just health benefits, but day care centers, training programs, and legal services. 29 U.S.C. § 1002(1). ERISA health plans may run hospitals or medical centers. *See De Buono*, 520 U.S. at 810 (noting that ERISA plan "owns and operates three medical centers"). Given the breadth of possible investing activities for pension plans and the range of services that a welfare plan might provide, Congress could not have contemplated that plans would be essentially exempt from generally applicable state regulations in these fields.

In concluding otherwise, the Second Circuit relied on a "literal approach to preemption" that both the Sixth Circuit and the dissent rightly criticized. *Self-Ins. Inst. of Am., Inc. v. Snyder*, 761 F.3d 631, 639 (6th Cir. 2014) (*SIIA*), *petition for cert. pending*, No. 14-741 (filed Dec. 18, 2014); App. 32 (Straub, J., dissenting) (noting that "majority's argument misses the nuance of what 'reporting' means in the context of ERISA"). The Second Circuit reasoned that reporting means "record-keeping and filing with a third party," App. 24, and Vermont's statute is titled a "'Healthcare Claims Uniform *Reporting* and Evaluation System,'" *id.* In so doing, the court committed an error similar to the one identified in *De Buono*, where this Court noted that the court of appeals "fail[ed] to give proper weight to *Travelers*' rejection of a strictly literal

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and requiring a "property transfer return" to "be delivered to a town clerk at the time a deed evidencing a transfer of title to property is delivered to the clerk for recording"); *id.* tit. 27, § 342 (recording of deeds).

reading" of ERISA's preemption clause. 520 U.S. at 812-13.

This Court has never held that all state laws that require plans to provide information intrude on a core ERISA function. *Fort Halifax*, upon which the court below relied (App. 16-17), certainly does not go so far. In that case, the Court upheld a Maine statute that required one-time severance payments to certain employees. The Court held that the law neither required employers to establish plans nor "create[d] the potential for the type of conflicting regulation of benefit plans that ERISA was intended to prevent." 482 U.S. at 14.

The Second Circuit placed great weight on the Court's observation, in finding Maine's statute not preempted, that ERISA preemption is intended to allow for a "uniform administrative scheme" and to avoid "differing regulatory requirements in different States." App. 16-17 (quoting *Fort Halifax*, 482 U.S. at 9). Read in context, however, *Fort Halifax* highlighted Congress's concern with "conflicting or inconsistent" state laws requiring certain kinds of benefits, claims processing, or fiduciary standards. 482 U.S. at 9 (quotations omitted). The Court noted that ERISA prevents conflicting state laws that would require a plan "to make certain benefits available," "to process claims in a certain way," or "to comply with certain fiduciary standards in some states but not in others." *Id.* The Court's reference to state laws that would require a plan "to keep certain records in some states but not in others" must be read in the same context—as related to state regulations that interfere with the plan's uniform administration of benefits. *Id.* at 9-11 (citing *Shaw* and noting concern that States would mandate different types of benefits); *see also Egelhoff*,

532 U.S. at 150 (noting that ERISA preemption avoids "differing state regulations affecting an ERISA plan's 'system for processing claims and paying benefits'") (quoting *Fort Halifax*, 482 U.S. at 10).

In any event, the lower court's broad reading of *Fort Halifax* cannot be reconciled with this Court's later decisions, which upheld generally applicable state statutes that imposed administrative burdens—including informational and recordkeeping requirements—on plans. The garnishment statute upheld in *Mackey* required plans to become parties to litigation, respond to a summons, and deposit funds (moneys otherwise due beneficiaries) into court. *See* 486 U.S. at 831. Despite these burdens, the court held that "Congress did not intend to forbid the use of state-law mechanisms of executing judgments against ERISA welfare benefit plans." *Id.* at 831-32; *see also Travelers*, 514 U.S. at 662 (re-affirming *Mackey*). *Dillingham* upheld California's prevailing wage laws and apprenticeship standards, 519 U.S. at 330, 334—laws that necessarily required ERISA plans to maintain records. *See id.* at 332-34 (noting plans faced choice of complying with standards or paying apprentices higher wages as required by prevailing wage statute).[25] *De Buono* upheld, as applied to plan-run facilities, a tax on the gross receipts of hospitals and other medical centers. *See* 520 U.S. at 809-10, 815-16. And state tax laws, without doubt, require taxpayers to keep records and provide information to the government. *See SIIA*, 761

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[25] *See also New Jersey Carpenters & Trustees v. Tishman Constr. Corp.*, 760 F.3d 297, 300 (3d Cir. 2014) (observing that state prevailing wage statute "requires that every contractor and subcontractor keep a record detailing the worker's name, his or her craft or trade, and actual hourly rate of wages paid to each worker" and preserve records for two years).

F.3d at 638 (noting that "neither *Travelers* nor *De Buono* explicitly concerned reporting requirements regarding the taxes, but those requirements were essential parts of the tax schemes and drew no comment").[26]

c. Liberty Mutual mistakenly insists that the health care database statute must be preempted because it requires "reporting of information 'about the essential functioning of employee health plans.'" Opp. 17 (quoting App. 29 n.13). Again, the data supplied to VHCURES do not identify plan participants, exclude denied claims, and say nothing about the terms of a plan or its funding. That is hardly a detailed report on the administration of an employee benefit plan. *See* App. 38 (Straub, J., dissenting) (noting that "Vermont does not seek information on plan assets, and does not review the allocation or denial of benefits"). If Liberty Mutual's suggested standard—that States cannot seek information related to "essential functions"—is broad enough to include Vermont's data collection, it would also cast doubt on common state laws that protect public health and safety. Plan-run hospitals would not have to report infections, mortality, or other public health data. Day care centers run by ERISA plans could not be required to report on attendance, safety measures, or teacher qualifications. States could impose taxes and prevailing wage standards, but not collect the information needed to enforce those laws from ERISA plans. *Travelers* and *De Buono* rejected such an expansive application of ERISA preemption.

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[26] As the Sixth Circuit noted, the tax upheld in *De Buono* "required '[e]very hospital [to] submit reports on a cash basis of actual gross receipts received from all patient care services.'" *SIIA*, 761 F.3d at 638 (quoting N.Y. Pub. Health Law § 2807-d(7)(a) (McKinney 1993)).

d. Because Vermont's law does not intrude on any core ERISA function, the Second Circuit's extended discussion of the supposed burdens of providing claims data was irrelevant. (It was also unsupported and factually incorrect, as discussed below. *See infra* pp. 52-56.) The court's holding that ERISA permits only a "slight" burden on plans, App. 24, is unsupported by precedent. ERISA does not preempt generally applicable laws merely because they place some financial or other burdens on ERISA plans. Indeed, that is precisely the proposition that *Travelers* —followed by *De Buono* and *Dillingham*—rejected. As the dissenting judge below recognized, "[m]any state laws may have an impact on the administration of an ERISA plan" and "impose additional costs" or "require additional administrative resources." App. 42 (Straub, J., dissenting). Providing claims data to state databases may impose some costs on third-party administrators for plans, just as the garnishment proceedings, rate surcharges, and taxes in *Mackey*, *Travelers*, and *De Buono* imposed costs. Liberty Mutual did not prove that fact, *see infra* p. 54, but, even if it is true, database laws nonetheless have no significant connection with ERISA plans and are not preempted.

3. Other federal enactments and federal support for state data-collection programs provide further evidence that Vermont's health care database statute is not preempted.

Not only do the purposes of ERISA weigh decisively against preemption, so too do other federal statutes and programs that encourage, support, and rely on state data-collection programs. Here, as in *Travelers*, other statutes passed contemporaneously with ERISA both are relevant and confirm that Congress did not

intend to preempt state efforts to collect and analyze health care information. *See Travelers*, 514 U.S. at 664-67 & n.6. Later federal statutes and programs only strengthen the case against preemption. The federal government has consistently supported both state data-collection programs and health care policies that depend on those data.

a. This Court's ruling in *Travelers* was informed in part by a statute adopted within a few months of ERISA, the National Health Planning and Resources Development Act of 1974 (NHPRDA), which encouraged States to regulate health care rates. *See* 514 U.S. at 665-66. Interpreting ERISA to preempt rate regulation, the Court noted, "would have left States without the authority to do just what Congress was expressly trying to induce them to do." *Id.* at 667. Both that reasoning and NHPRDA itself are relevant here and show that Congress likewise could not have intended ERISA to preempt state data-collection efforts.

NHPRDA, as the Court recognized in *Travelers*, promoted and funded "regional 'health systems agencies' *responsible for gathering data* as well as for planning and developing health resources." 514 U.S. at 665 (citing § 3, 88 Stat. 2229-2242) (emphasis added). Part of Congress's charge to those agencies was to "assemble and analyze data concerning," among other things, the health care delivery system and its use, "the number, type, and location of the area's health resources, including health services, manpower, and facilities," and "patterns of utilization." NHPRDA § 3, 88 Stat. 2236 (adding § 1513(b) to the Public Health Service Act (PHSA), codified at 42 U.S.C. § 300*l*-2(b) (1976) (repealed 1986)). NHPRDA, in turn, cross-referenced, *see id.*, another federal statute passed earlier that

year, the Health Services Research, Health Statistics, and Medical Libraries Act of 1974. That statute created the National Center for Health Statistics and directed the Center to, among other things, assist "in the design and implementation of a cooperative system for producing comparable and uniform health information and statistics at the Federal, State, and local levels." § 105, 88 Stat. 365-66 (adding § 306(e) to the PHSA, codified at 42 U.S.C. § 242k(e) (1976)). *See supra* pp. 6-7.

These federal programs, contemporaneous with the adoption of ERISA, provide necessary context for evaluating the scope of Congress's intent in ERISA to preempt state laws. The same Congress that passed ERISA was also deeply concerned with health care reform, and it contemplated both a substantial state role in developing health care policy and reliance on comprehensive data about state health care systems. *See Travelers*, 514 U.S. at 665-67. Here, as in *Travelers*, it "just makes good sense" to reject a broad interpretation of ERISA preemption that would leave "States without the authority to do" the work that other federal statutes promoted and supported. *Id.* at 667.

b. Moreover, although this part of NHPRDA was repealed in 1986, federal laws and policies continue to "encourage and rely on state experimentation." *Travelers*, 514 U.S. at 667 n.6. *Travelers* noted that the "history of Medicare regulation," including waivers and implementing programs that post-date ERISA, "confirm[] that Congress never envisioned ERISA pre-emption as blocking state health care cost control." *Id.* Medicare and Medicaid waiver programs still exist. Among other things, the federal government supports state "all-payer" models for health care

payment and delivery. *See* U.S. CVSG Br. 21; 42 U.S.C. § 1315a(b)(2)(B)(xi) (contemplating "[a]llowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State"). Evaluating those models depends upon state claims databases. *See* U.S. CVSG Br. 21-22; 42 U.S.C. § 1315a(b)(4) (requiring evaluation of models, including review of quality of care and changes in spending). Indeed, the federal government has provided grants to fund database development, as States "test and evaluate" innovative health care delivery models.[27]

Vermont's Global Commitment waiver for Medicaid allows the State to use federal funds for certain public health initiatives and infrastructure. Some of those funds are used to support VHCURES. VHCURES also collects and processes Medicaid claims data.[28]

c. The fact that Congress has specifically authorized providing Medicare claims data to States seriously weakens any argument for federal preemption. The Secretary of Health and Human Services may

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[27] *See, e.g.*, CMS, State Innovation Models Initiative: Model Test Awards Round Two, http://innovation.cms.gov/initiatives/state-innovations-model-testing-round-two/; *see also* New York et al. Cert. Amicus Br. 3 (describing $6.5 million federal grant for Connecticut's database).

[28] *See* CMS, Expenditure Authority, Global Commitment to Health Section 1115 Demonstration, at 3 (authorizing expenditures for certain "public health initiatives" and "infrastructure"), http://dvha.vermont.gov/administration/2vt-global-commitment-expenditure-authority-cms-approved-10-2-13.pdf; 2015 Vt. Acts & Resolves No. 58, § E.345; Dep't of Vt. Health Access & Green Mountain Care Bd., Memorandum of Understanding, *available at* http://dvha.vermont.gov/administration/sfy15-gmcb-mou-signed.pdf; Dep't of Vt. Health Access & Green Mountain Care Bd., Memorandum of Understanding, *available at* http://dvha.vermont.gov/administration/gmcb-dvha-mou-signed.pdf.

provide the claims data to "qualified entities," including States, that "use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use." 42 U.S.C. § 1395kk. As the United States has explained, this provision shows that Congress "recogniz[es] the importance of access to comprehensive claims data for healthcare evaluation purposes." U.S. CVSG Br. 22. It would hardly make sense for Congress to take steps to provide access to Medicare claims data to States, if ERISA stood as a roadblock to building comprehensive all-payer databases.

d. Finally, the Patient Protection and Affordable Care Act (ACA), too, acknowledges and preserves the States' primary role in regulating health care. Even with this substantial investment of federal resources in expanding health care coverage, Congress adhered to a federalist structure. *See, e.g.*, 42 U.S.C. § 18041 (state flexibility in establishing and operating exchanges); *id.* § 18052 (waivers for state innovation); *id.* § 18041(d) ("[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title").

Not only do States continue to regulate health insurers, but also the federal government has expressly supported and helped fund the use of all-payer databases for this purpose. The ACA, which mandates certain rate reviews, preserves the States' regulatory role so long as States are able to conduct those reviews effectively. *See, e.g.*, 45 C.F.R. § 154.210. Just last year, the federal government awarded the Green Mountain Care Board a million-dollar-plus grant, in part to "expand its use of its All-Payer Claims Database (VHCURES) to support its efforts to integrate rate review into the larger landscape of health care

reform activities and increase medical pricing transparency."[29] Grants to other States also support use of APCDs to improve the rate review process.[30]

The federal government's consistent respect for the States' traditional role in regulating health care and its partnering with States to develop and review innovative programs make the case for finding Vermont's database law preempted especially weak. There is no reason to think that Congress intended ERISA to block States' access to critical information about their health care markets while at the same time expecting States to administer complex health care systems, regulate health insurers, and experiment with payment reform and other innovative policies.

C. Because the Court presumes that Congress did not intend to preempt state law, any question regarding the scope of preemption must be resolved in Vermont's favor.

Given the "purpose and the effects" of Vermont's law, *Travelers*, 514 U.S. at 658, its minimal effect on ERISA plans, and consistent federal support for state collection of health care data, there is no question that this is the type of state law that "Congress understood would survive." *Id.* at 656. Were there any doubt, however, it would be erased by Liberty Mutual's failure to meet its "considerable burden of overcoming" the presumption against preemption. *De Buono*, 520 U.S. at 814. This Court has "unequivocally concluded" that ERISA's preemption language does not "modify

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[29] CMS, Vermont Rate Review Grants Award List, https://www.cms.gov/cciio/Resources/Rate-Review-Grants/vt.html.

[30] *See* CMS, Rate Review Grants, https://www.cms.gov/cciio/Resources/Rate-Review-Grants/ (describing grants involving APCDs made to, among others, California, Colorado, New Hampshire, New York, Rhode Island, and Utah).

'the starting presumption that Congress does not intend to supplant state law.'" *Id.* at 813 (quoting *Travelers*, 514 U.S. at 654). "[W]here federal law is said to bar state action in fields of traditional state regulation, [the Court has] worked on the assumption that the historic police powers of the States were not to be superseded . . . unless that was the clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655 (citation and quotations omitted).

Although the Second Circuit resisted the presumption against preemption on the ground that Vermont's database program does not regulate health care directly, App. 18-19 n.8, this Court's precedents teach otherwise.[31] Both *Travelers* and *De Buono* illustrate that the State's police powers extend more broadly than regulating "the safe and effective provision of health care services." *Id.* In *Travelers*, the Court applied the presumption to state-mandated hospital surcharges that gave preferential treatment to certain insurers and payers. 514 U.S. at 649-50, 655, 658. And, in *De Buono*, the Court criticized the Second Circuit for failing to apply the presumption to a state tax on hospital revenues. 520 U.S. at 814 & n.10. Though the tax was a "revenue raising measure, rather than a regulation of hospitals, it clearly operate[d] in a field that has been traditionally occupied by the States." *Id.* at 814 (quotations omitted). That the tax targeted the health care industry "support[ed] the application

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[31] The Second Circuit also declined to apply the presumption against preemption because "collecting data can hardly be deemed 'historic'—most such laws were enacted only within the last ten years." App. 18 n.8. The court was wrong about the history of health data collection, *see supra* pp. 4-8, but, regardless, the Court has not held that new forms of public health regulation fall outside the States' historic police powers.

of the 'starting presumption' against pre-emption." *Id.* at 814 n.10.

Liberty Mutual has offered no evidence or argument sufficient to overcome the presumption. Liberty Mutual's consistent refrain has been merely that ERISA preempts any requirement that its third-party administrator "report" on its plan's activities. *See, e.g.*, Opp. 20. At most, Liberty Mutual has contended (though not proven) that complying with the law or other similar laws imposes administrative burdens for its third-party administrator. *See* Opp. 20-21.[32] It has not suggested, nor could it, any cognizable impact on the plan's "system for processing claims and paying benefits." *Egelhoff*, 532 U.S. at 150; *see* App. 44 (Straub, J., dissenting) (noting that no "evidence of a burden on the system for processing claims" was provided, and "the majority points to none"). Liberty Mutual's conclusory arguments do not approach the showing necessary to overcome the presumption against preemption.

II. The Second Circuit's conclusion that Vermont's database law places improper burdens or risk on Liberty Mutual lacks merit and finds no support in the record.

In holding Vermont's law preempted, the Second Circuit assumed that providing information for Vermont's database "is burdensome, time-consuming, and risky." App. 25. But, as the dissenting judge below recognized, "[t]here is no evidence to support

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[32] The Second Circuit noted a potential "risk of fines." App. 29. But Liberty Mutual's third-party administrator risks a fine only for *not* complying with the statute. The same would likely be true if a plan failed to pay a state tax or comply with a prevailing wage law. The fact that a state law has some provision for enforcement does not mean it is preempted.

such a finding." App. 46 (Straub, J., dissenting). The court's analysis of the supposed burdens of complying with Vermont's database statute is deeply flawed.

First, Liberty Mutual itself is not required to report anything to VHCURES. The only reporting obligation relevant here—and the only issue before the Court—is the obligation of Blue Cross to provide its Vermont claims data to VHCURES.[33] In evaluating potential burdens, this fact matters. Blue Cross is a major health insurer that generates claims data as part of its regular business as an insurer and plan administrator. Liberty Mutual admits that Blue Cross has the data. *See* App. 39 (Straub, J., dissenting) ("The Vermont statute asks for after-the-fact information which plan administrators, such as [Blue Cross], already have in their possession.") (citing Oral Arg. Tr. 7-8). And the record shows that Blue Cross provided claims data to VHCURES for thousands of individuals covered by its own plans and other self-insured ERISA plans. JA205. Liberty Mutual's Vermont resident plan members represent only a tiny fraction of that number. There is no evidence or even reason to assume that Blue Cross would incur any significant cost by including the claims data for Liberty Mutual's 137 Vermont beneficiaries in its VHCURES submissions.

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[33] The regulation expressly defines "health insurer" to include third-party administrators. App. 112. With respect to self-insured plans, however, the regulations provide only that the term "may also include, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan." App. 113. Vermont has had no occasion to interpret this latter provision of the regulation and is not aware of any self-insured health plans operating in Vermont without a third-party administrator. The only question in this case is whether VHCURES is preempted as applied to the third-party administrator for a self-insured plan.

In fact, one might reasonably assume the opposite: that the third-party administrator incurred some cost to ensure that the data were excluded.

Second, the court below deemed the reporting requirements "time-consuming" and "burdensome," App. 25, without citing any evidence. Liberty Mutual, which moved for summary judgment in the district court, "failed to provide any details or showing of the alleged burden." App. 39 (Straub, J., dissenting); *see* App. 72-73 n.5 (district court noting that Liberty Mutual "has not submitted any information about any actual burden suffered by itself or [Blue Cross] in producing this information"). Liberty Mutual told the district court that the extent of any burden, whether "heavy" or "relatively light," was irrelevant. C.A. JA356-57 (district court hearing transcript). It suggested to the Second Circuit that providing information is "*per se* burdensome" because "all regulations have their costs." Liberty Mutual C.A. Br. 27-28 (quotations omitted). Here, Liberty Mutual deems the supposed burdens "obvious." Opp. 21. But the absence of a single affidavit attesting to the cost or time required to provide claims data to VHCURES is both revealing and dispositive. The burden here was Liberty Mutual's, both to prove its case and to overcome the presumption against preemption. Certainly the fact that Blue Cross provides *the same information to Vermont* for itself and other plans that it administers conclusively rebuts any assertion of burden. *See* App. 39 (Straub, J., dissenting) ("by all accounts [Blue Cross] is happy to provide the data Vermont has asked for, and it does so for other clients"); App. 72-73 n.5 (Blue Cross "apparently provides the data without protest on behalf of other self-funded plans"); JA205

(in 2010, Blue Cross provided claims data for more than 7,000 individuals).

Third, setting aside the lack of evidence, the court erred in thinking it was "obvious[]" (App. 25) that requiring health care insurers and third-party administrators to submit claims data is particularly costly or burdensome. Insurers generate claims data as part of their everyday business. *See* App. 51 (noting that Blue Cross "generates claims data"). That is how doctors and hospitals get paid. Again, Blue Cross has the information that VHCURES seeks. *See* App. 39 (Straub, J., dissenting) (noting this is "after-the-fact information" that Blue Cross has "in their possession"). Liberty Mutual objects to certain formatting requirements that Blue Cross must satisfy—but just as forms used to be printed in blue or black ink, forms today have certain electronic formatting requirements. That is nothing unusual, particularly for billion-dollar businesses that routinely collect and transmit data. The Second Circuit implied that the amount of information sought necessarily made compliance burdensome. App. 25-27. Here again, the court's assumptions are disconnected from current technology and business practices. Reams of information may be transmitted with a few key strokes.

Fourth, the lower court's suggestion that the VHCURES program jeopardizes patient confidentiality was equally unsupported and incorrect. By rule, personal identifying information is encrypted in a manner that does not allow the underlying data to be recovered. App. 110. The statute unambiguously requires compliance with HIPAA. App. 96. The federal government voluntarily supplies Medicare claims data to VHCURES, on the condition that Vermont protect patient confidentiality. *See* U.S. CVSG

Br. 17-18 n.7. Liberty Mutual supplied no evidence suggesting any breaches of patient privacy by VHCURES. As the dissenting judge below concluded, the court's assertion that providing claims data to VHCURES was "risky" was "nothing more than pure speculation." App. 46 (Straub, J., dissenting).

CONCLUSION

The decision below should be reversed.

Respectfully submitted,

DAVID C. FREDERICK
SCOTT H. ANGSTREICH
KELLOGG, HUBER, HANSEN, TODD, EVANS & FIGEL, P.L.L.C.
1615 M Street, N.W
Suite 400
Washington, D.C. 20036
(202) 326-7900

PETER K. STRIS
BRENDAN S. MAHER
RADHA A. PATHAK
STRIS & MAHER LLP
725 S. Figueroa Street
Suite 1830
Los Angeles, CA 90017
(213) 995-6800

WILLIAM H. SORRELL
Attorney General
BRIDGET C. ASAY
Solicitor General
Counsel of Record
BENJAMIN D. BATTLES
Assistant Attorney General
OFFICE OF THE ATTORNEY GENERAL
109 State Street
Montpelier, VT 05609
(802) 828-3181
bridget.asay@vermont.gov

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